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THE FAMILY LIFE CYCLE--PERSPECTIVES DRAWN FROM FAMILY THERAPY, PRESCHOOL THROUGH ADOLESCENCE.

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PUB DATE MAR 68

EDRS PRICE MF-$0.25 HC-$0.88 20P.

DESCRIPTORS- FAMILY COUNSELING, *FAMILY RELATIONSHIP, *GROUP THERAPY, *FAMILY LIFE, PATHOLOGY, *EMOTIONAL DEVELOPMENT,

A DEVELOPMENTAL FRAME OF REFERENCE WAS USED AS A WAY OF VIEWING THE EMERGENCE AND/OR PERPETUATION OF PATHOLOGY IN A FAMILY. THIS FRAME OF REFERENCE INCLUDES SEVERAL ACCOMPANYING CONCEPTS. RESISTANCE TO CHANGE IS SEEN AS A FUNDAMENTAL DYNAMIC FACTOR IN FIELD (FAMILY) PATHOLOGY WITH INTERPERSONAL SUBSYSTEMS WITHIN THE FAMILY ACTING AS PERPETUATORS OF PATHOLOGY AND RESISTANTS TO CHANGE. PHASE-APPROPRIATE ADAPTIONS MADE BY THE FAMILY INCLUDE--(1) BASIC NURTURING, (2) ENCOURAGING EMERGING AUTONOMY, (3) ORGANIZING INSTRUMENTAL ACTION, (4) CLARIFYING REALITY, AND (5) FACILITATING DYADIC RELATIONSHIPS. PATHOLOGIC COMPENSATORY MECHANISMS OPERANT WITHIN A FAMILY ENSURES THE SUCCESS OF EACH OF THE PHASES FOR THE CHILDREN, BUT AT THE PENALTY OF CREATING INTERPERSONAL SUBSYSTEMS WHICH RESIST CHANGE AND NORMAL DEVELOPMENTAL PROGRESSIONS. THE CONSEQUENCES ARE EITHER HIGH POTENTIAL FOR PATHOLOGY OR A PERPETUATION OF EXISTING PATHOLOGY. THIS PAPER WAS PRESENTED AT THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION ANNUAL MEETING (CHICAGO, MARCH 1968). (CG)

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THE FAMILY LIFE CYCLE: PERSPECTIVES DRAWN FROM FAMILY THERAPY, PRESCHOOL THROUGH ADOLESCENCE *

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Family group therapy leads naturally into the study of how families accommodate to or resist change. Many of the early theoretical formulations about family therapy are addressed in one way or another to this theme of change. Ackerman's term, "equilibrium-disequilibrium," and Jackson's phrase, "familial homeostatis," each are references to this. The elaborate mechanisms with which disturbed families seem to protect themselves against the encroachment of changing life's experiences have been described by many of the "pioneer" studies in the field. These have described the rigidity, in disturbed families, of belief systems, internal object orientations, role designations, role behavior, and of communication and even cognitive-perceptual patterns. Against these powerfully entrenched and highly organized subsystems within certain families, therapeutic interventions seeking major change often flounder.

CLINICAL WORK WITH PRESCHOOL CHILDREN AND THE DEVELOPMENTAL PERSPECTIVE

Those of us who work with families in relation to disturbed preschool children are inevitably involved with the issue of developmental progressions or transitions, and the intrafamilial resistances to these. Some of this becomes re-dramatized once again in adolescence. In my presentation, however, I will draw from our work with preschool children. In cases where the young child's psychopathology is marked,

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* Presented at American Orthopsychiatric Association Annual Meetings, Chicago, Illinois, March, 1968.

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parental failure to provide phase-appropriate reinforcement of emerging developmental functions can be quite easily demonstrated. The circularity process in this is also fairly easily observed and it is a crucial factor since it tends toward self-perpetuation. It can be argued that ultimately it is perpetuation and not causation that is our clinical concern.

SEVERE PATHOLOGY DEFINES DEVELOPMENTAL FAILURES

One example is in the case of an autistic boy of three who began to use words by twelve months, but stopped, and some months later developed echolalic and chanting-type speech together with a diffuse attitude toward people. From the history it became clear that by the end of his first year of life mother had become seriously immobilized by recurring anxiety attacks and chronic depressiveness. This was precipitated by her severe disillusionment with her marriage. Her husband was extremely inept as both husband and father, and he was not able to fill in as an effective parenting figure for the infant. The child's failure to progress verbally deepened mother's anxiety and her sense of failure, leading her to act in an ever more compulsive, but also regressive, fashion with him. By the time he reached two, his "oddness" was evident and troubling to both parents, but they also found a certain charm in it. Some aspects of his regressive behavior were syntonic for mother (i.e., his infantile cuddling and his anal-erotism). His failure to evolve autonomous behavior of a phallic-aggressive sort was syntonic with the father's severe and very evident castration anxiety. The boy's manifest developmental defectiveness served almost as a concrete externalization of each parent's profound self-depreciation and this was observable repeatedly in family sessions.

Each seemed incapable of imagining himself or herself parent of a healthy, vigorous child. In addition to all this, the child's peculiarity distracted them from the painful disappointment each felt in the other. In family sessions with them, a kind of helpless-hopeless feeling tone pervaded, punctuated by recurring outbursts of anger and frustration toward each other. Neither of them could provide leadership or encouragement for vigorous autonomous exploratory behavior that would be phase-appropriate for a three to four year old child. Neither fully expected vibrant dyadic interaction from him. They settled almost too readily for his stereotyped nonfocussed way of relating to them. The enmeshment by each parent in his and her own separate psychopathology, reinforced and elaborated by the pathologic marriage and reamplified all over again by the child's actual pathology, provided (and continues to provide) a formidable therapeutic undertaking.

An item of background data in this case was the continuing very active involvement by each parent with her and his own parents. This is a suggestive item. We have been repeatedly impressed with the high number of instances, in our therapeutic nursery school, of young parents still openly dependent upon at least one set of grandparents. Frequency of visits and of phone calls to one another's houses, and much enmeshment in each other's affairs has been our observation.

Out of clinical experiences such as this, and others that are far less pathologic, has come a conviction that there is some clinical profit in attempting to define a familial developmental cycle, parallel with and complementary to individual life cycles. The notion here is that the sequence of developmental phases that a child moves through

requires a constant series of accommodations by each family member. In the case I have presented, it would appear that the family group is bogged down in all phases of the hypothetical family developmental cycle. In family life, intrafamilial accommodations occur both intrapsychically and interpersonally through time. In other words, an active process of intrafamilial maturation and development goes on both as a response to the developmental changes the children introduce from one phase to the next, and also as a result of the maturation occurring within each parent as new life's events unfold.

PHASE-APPROPRIATE EXPERIENCES FOR THE FAMILY GROUP

Casting this into a form taken from the well accepted model of an individual developmental cycle, we hypothesize the possibility of phase-appropriate experiences for the total family group which can be usefully defined. Analogizing from Erik Erikson's formulations, we might further hypothesize that failure by the family group to work through one phase of the family developmental cycle impairs its capacity to effectively move through subsequent phases. A subproposition is that distortions or deficiencies of intrafamilial experience in one phase are carried forward into subsequent phases as persisting and potentially disruptive interpersonal subsystems in the familial field.

These propositions are based upon and even introduce an enormous number of variables, the mere listing of which might take the next few minutes. Instead, I would like to designate a few constructs that may serve to organize all of this with some ultimate value for clinical practice.

VARIOUS FRAMEWORKS FOR FAMILY THERAPY AND RESISTANCE TO CHANGE

A first set of constructs responds to the differing emphases that characterize those who work with families. As Meissner has so well described, there are those who work more with a psychoanalytic-psychodynamic frame of reference; those who are intrigued with the powerful effects of distortions and confusions of communication; those who work with role theory and its many variations; and those who move toward behavioral and even cognitive-perceptual models for their study and clinical intervention. I doubt that any would claim an exclusiveness of knowledge or effeetiveness in their own approach and I imagine that each would be inclined to admit his dependence upon all the others (publicly, that is!). Probably those who address themselves to "intrafamilial transactions" are attempting to cross the lines of all that I have just listed. It is my own belief that one possible organizer for most of the variables that are contained in these various frames of reference lies in the notion of the familial field as a system in a constant state of transition or change and in which resistances to change become organized in a variety of ways. In other words, clinically observable pathologic subsystems and patterns and disturbances of behavior and/or function are all representations of resistance to change in the familial field. The value, ultimately, for such an organizing concept as resistance to change is that it helps to provide us with an ordering of clinical priorities, all against the backdrop of both structure and process within families. Such an ordering of priorities is what might best be labeled clinical management. Much of what I have said is borrowed from action concepts in sociology where resistance to change is studied in social institutions and where self-perpetuating social systems are defined.

SOME BASIC FAMILIAL DEVELOPMENTAL FUNCTIONS

A next set of constructs relates to what appears to me to be the predominant developmental issues that a family as a group must attend to over time.

The Family as a Nurturing System

The first of these developmental issues has to do with basic nurturing. When an infant arrives in a family, the fundamental accommodation that must be made by all participants is one that insures the infant's survival. This includes not only feeding, but holding, calming, stroking, stimulating, and so on. All that Winnicott would characterize as "good enough mothering," or that Bowlby might consider the fulfillment of "attachment behavior." I would like to emphasize, however, that this is a totality of experience and not simply something provided by the mother, even though in certain cultures it does seem that the natural mother is the most direct and effective provider for this. There are many other possibilities, however. (Even in the United States, welfare workers have often observed that much of an infant's mothering may be carried out by latency age siblings in certain households.) It is the final effect that I am focusing upon. Somehow, the family group, regardless of how many people constitute it, must accommodate to the infant with a nurturing attitude and action. Siblings must adapt and parents must provide leadership. The change that a new infant introduces into the family system, however, may be such that a particular family falls off from meeting the minimum requirement for nurturing the infant and many difficulties ensue. These may show up at first as individual psychopathology in one or another family member. A post-partum depression in the mother or a psychotic-dissociative reaction in the father are extreme but known examples.

Absolute failures of adequate familial response to the nurturing phase show themselves most definitively through symptoms in the infant. These range from obvious physical conditions, such as malnutrition, to the more indirect evidences, such as the anaclitic depressions of Spitz, or the serious but sometimes subtle developmental lags of the first year described by Provence and others, occurring in institutionalized infants. The symptoms of severe failure of nurturing may show up as physiological imbalances in the infant (hyperactivity, overexcitability, sleep disturbance, frequent vomiting, proneness to infection, etc.).

Intrafamilial compensatory mechanisms for meeting the nurturing needs of an infant but which <u>need not</u> lead to subsequent intrafamilial pathology would be the "taking over" of the care of the new infant by a competent grandmother or in-law or an older sibling or some equivalent. The potential for pathology is high, however, if the nurturing resources arise out of defensive and/or compulsive drives. An example of this would be a grandmother who <u>needs</u> to take over out of her need to make restitution for her failures when she was a young mother, or out of a need to infantilize her daughter, or out of her need to restore object relationship for herself through the grand-infant. This may become then the nexus for complex intrafamilial dynamics, inviting regressive alliances, confusion of parental and marital roles, and so on. All of this becomes carried forward to a next development phase of the family as a breeding source for more pathological mechanisms.

Another potentially pathologic resource for compensatory nurturing may arise out of the father's regressive identification with the infant. His reaction to the mother's imperfect nurturing (if, for example, she

goes through a post-partum depression) may be to identify with the "deprived infant" and to amplify a symbiotic relationship with it. This again may lead to basic distortions in the overall nurturing environment of the family, even though the infant itself may receive what it needs. The necessary familial maturation, however, fails to occur in the nurturing phase in such a way that the subsequent phases can unfold optimally. Interpersonal subsystems which serve such major compensatory functions become self-perpetuating and provide resistance to normal transition and change. The penalty may be both that the family fails to evolve a vibrant, nurturing orientation, which erodes its ability to meet the other areas of family function; and the family develops a high potential for disturbance because maturation of each member is blocked in some degree.

The Family as Encourager of Emerging Autonomy

A second essential familial accommodation must be to the fact of gradually emerging bits of behavioral autonomy on the child's (and all of the children's) part. This begins, of course, very early, but has its most popularly described character in the anal-motile phase. Earlier, with creeping and space exploration and object manipulation, it is already well on its way. This group accommodation to emerging autonomy is a total project for the family and there may be many pockets of resistance. Once again, the impact of this may be such that one or another family member shows a clinical reaction--possibly the child itself. A complex interpersonal subsystem may emerge. Successful accommodation to autonomy requires a sensitive response to the infinite bits of self-expression that each person, but particularly the child, shows, oscillating with momentary or sometimes more prolonged returns to dependency refuge. Mahler has

reviewed much of this in her studies of individuation apropos of the mother-infant unit. Implementing this requires a carry-over of the nurturing orientation that the family unit has developed in the previous phase.

The effect of all this on some family groups, especially the parents, may be to mobilize neurotic and/or regressive tendencies. Some mothers may respond to the autonomous pressures of the infant (and the other children) with separation anxiety. Others may feel the infant's independence-striving as a pressure for control or a dominance-submission struggle. The same may be said of the fathers. A family group poorly equipped to meet autonomy may become enmeshed in a variety of interpersonal struggles leading to overt or passive aggression, obstinacy, extreme sibling competitiveness and rivalry, and an erotization of any of these.

We see many family groups that grant autonomy far too soon. Counterphobic or pseudo-mature behavior results, which precipitates complicated intrafamilial subsystems of transaction. These become self-perpetuating and polarize the family life. Maturation for all may be affected. What I feel impelled to emphasize is that the pathologic mechanisms that develop are group mechanisms and intra-psychic ones. The resistance to change which they introduce may be formidable and enduring.

The Family as Organizer of Instrumental Action

A third developmental accommodation has to do with the need for the child to receive direction in and response to the organization of instrumental functions. This includes effective use of language as well as the carrying out of small bits of executive action inter-personally and with inanimate objects. Clearly, this is not just

father's job, as has been implied in some theories of marital organization. Women are certainly as effective as men in meeting the administrative requirements of family life. Direction and support for this must arise from at least some quarter within the family matrix. Clarity, action-leadership, and specific goal direction are all essential. Many families provide confusing if not totally inadequate language. Minuchin has described these. There are families that have been well described by now who cannot seem to really define, let along carry out, any major goal or project. Decisions are cancelled out. Nothing happens. But even a single rather authoritarian family member may be able to compensate for all this--may be the one who mobilizes everyone or defines directions. If this is the case, it may be at the expense of creating a potentially pathologic interpersonal subsystem between one or several members in relation to dominance-submission. The family mobilizer may also be the family tyrant. The total family experience with nurturing and with autonomy affects its orientation to action.

The Family's Clarification of Reality

A fourth developmental requirement that the family group must be able to provide is a verbal and non-verbal communication system through which omnipotent fantasy can be differentiated from realizable reality. This is a relative matter for each family group. What might be only fantasy for one family is in fact quite realizable for another. But, somehow, the family must function so that these issues become clarified for each member at critical times. This is not uni-directional from parent to child. Pumpian-Mindlin has pointed out how the "omnipotential tendencies" of the adolescent provide corrective pressures upon the

parents. Also, in day to day living, spouses do this for each other. It has commonly been observed that disturbed families tend to be socially isolated, again reducing the possibility for correcting omnipotent fantasies. The communication patterns in disturbed families blur reality on many levels. Such blurring may itself be a compensatory mechanism for masking the actual inability by the family members to meet various aspects of reality well. Failures to perceive and define the limits of fantasy, and the compensatory exaggerations and pathologic interpersonal subsystems derived from them, serve to distort the comprehension of reality and to inflate omnipotent self-perceptions and expectations. We have seen families polarized around a four year old who has already rigidified an omnipotent narcissistic character. The family's need for this, and the persisting reinforcement of it may be so great that change in such a subsystem becomes almost impossible. The original need to have precipitated such an unrealistic self-perception may reflect innumerable intrafamilial determinants, all the way from individual intrapsychic pathology in the parents at one end of the spectrum, to severe deprivational factors at the other end.

Multiple Dyadic Interactions

A fifth essential has to do with the provision of meaningful dyadic experiences within the family. Successfully worked through dyadic relationships lead to the ability to tolerate the ambivalence and regressive pressures that permeate intimate relationships. Working these through in everyday family life provides the prelude for experiencing the jealousies and terrors of the triadic involvements that characterize the oedipal phase. The many and varied distortions

of oedipal relationship with which we are all familiar are often outgrowths of distorted, overloaded, compensatory arrangements having evolved in the other developmental areas that I have referred to. Any of those may have served to twist or block the development of mutuality in dyadic experience.

I have suggested a more or less sequential series of familial developmental phases. Each of these might be described within the various frameworks that have come out of family therapy, i.e., psychoanalytic-psychodynamic theory; or role theory; or communication theory; or cognitive-perceptual theory. I have held more-or-less to a psychoanalytic-psychodynamic frame of reference. The phases I have described include broad spectrum intrafamilial nurturing; familial accommodation to the emergence of autonomous behavior; familial reinforcement of goal-directed, instrumental behavior and functions; familial clarifications of omnipotent fantasy versus reality; and familial encouragement of multiple dyadic intimacies, leading to the triadic intimacy of the oedipal phase.

In our work with preschool children who present major failures of development, we have observed that the family group has been unable to provide an adequate integration of experience within these categories. Although the familial development phases I have outlined relative to the young child are presented as sequential, I do not wish to force the issue. They are also overlapping. It does seem, though, that one can discern a peaking, so to speak, of each in some sequence. Again, I want to emphasize that each of the family therapy orientations I have reviewed earlier could view these phases within its own framework. The overall balance of the family experience in each developmental phase is what is of core concern; as well as the

ways in which the transition from one phase to the next becomes blocked and resistance to change operates.

USING THE PSYCHOANALYTIC FRAME OF REFERENCE

A variety of workers have intensively studied the mother-infant unit, more-or-less in transition. Out of these studies have come certain basic concepts such as mutual regression, partial or focal symbiosis, separation anxiety, identification and introjection, externalization, projective identification, and, more recently, multiple superego identities. Emphasis in the past was upon the id drives, the conflict, and the defenses that could be observed. Behavioral aspects of ego functions enter into more recent studies, with increasing emphasis on cognitive and perceptual functions.

In our clinical work, relying generally upon the psychoanalytic frame of reference applied to the <u>total</u> family rather than the mother-child unit, we find ourselves shifting our attention in a fairly rapid fashion from child need to parental need to maternal need to paternal need and even to sibling need. Within the term "need," I am including, here, both drives and defenses, without differentiating them.

Even in a first family group diagnostic session, we can quickly draw conclusions about the current climate of intrafamilial function. Admittedly, this is a slice-of-life or horizontal kind of observation and does not tackle the issue of transition or change except as it can be speculated upon from what one observes in such a diagnostic session. What the psychoanalytic frame of reference makes us especially sensitive to are identification processes, separation anxiety, partial symbiosis, regressive entanglements, sado-masochistic relationships, castration anxiety, ambivalence, and overloaded fantasy systems. How can these be traced in terms of familial developmental schema? Clinical experience with family groups opens the way.

Multiple Approaches to the Clinical Problem

There is no reason that we have been able to find that binds us to using only the family group interview as the basis for our work and study. We draw also from individually taken histories, single interviews, and, ultimately, for our research, from the long term daily participation by the children in our nursery school and from the extended series of family group interviews that we have carried out with approximately ten of our cases in the last three to four years. All of this creates a complex clinical feedback system which at first glance may seem confusing. When we hold closely to our guiding principle of resistance to change and to a psychodynamic frame of reference, we discover that a unified process of clinical understanding and management occurs for us.

I will try to develop an illustrative example where pathology is not so severe as in the earlier case I outlined.

In this instance, our estimation is that familial response to the nurturing phase was adequate for the infant, but only as a result of certain pathological compensations which I will refer to in a moment. The mother in this case was deeply enmeshed in a partial symbiotic dependency upon her own mother, which interlaced with a mutually provocative oedipal tie to her father. Her relationship with her husband was distant and depreciating. She was mechanically available but emotionally distant with her baby son. The compensatory nurturing became systematized in two ways: one was through father who identified with the emotional deprivation he perceived in his little boy and he became very nurturing to him; the second compensatory mechanism came from mother via an anal-erotic preoccupation on her part with the boy. Each of these compensatory systems became systematized as potentially

pathologic elements which took form in the next phase, the one of emerging autonomy. On the one hand, the boy and mother remained in a mutually regressive tie around anal functions. She provided frequent enemas and he went through disturbingly long periods of stool withholding. The father became the boy's ally and protector from the mother's frustrated rages. He felt chronically depreciated by his wife and helpless to get through to her; but he amplified his tie to his son and, also, he found unconscious gratification in the boy's retentive provocations of the mother. The mother's own continuing tie to her parents reflected her own separation anxiety which played into and reinforced her regressive tie to her little son. Neither parent was able to encourage broad scale, appropriate, autonomous, independent behavior. Encouragement of instrumental goal-directed behavior was lacking in a variety of areas because the phallic aspect of it threatened mother and because father, who was increasingly doubtful about his own phallic function, could not provide leadership. The familial function of differentiating omnipotent-fantasy from reality for all members suffered because mother's own fantasy enmeshment with her parents had never been worked through and husband was not able to break into this. The very symptom of feces retention with all of its attendant elements serves to amplify unrealistic fantasies of power and destruction in a child, and, of course, of unlimited omnipotence. The faulty dyadic relationship of the parents to each other limited their ability to provide leadership and model for their son and, instead, his dyadic ties to each of them were suffused with omnipotent control and regressive manipulation.

In this case, therapy was aimed at almost all levels. The child in the nursery school was encouraged to experience pleasure in instrumental and autonomous action (running, riding a bike, climbing, building blocks, finding language to express his feelings and his needs, etc.). Mother had not been able to underwrite these functions. In joint interviews, father was encouraged to speak his mind to mother and to take some courage in assertive phallic behavior. In joint and individual sessions, mother was helped to disengage herself from her parents. As this began to occur, her anal-erotic regression with her son increased temporarily, as it did for awhile when his symptom improved and their mutual involvement lessened. This reflected her separation anxiety. In individual therapy with the boy, he found encouragement to be phallic provocative, then anally messing, then phallic aggressive and verbally definitive. The working through of this dyadic experience with a therapist went hand in hand with experiences in the nursery school where he was urged to relate to other children, improving instrumental functions. His omnipotent fantasies about his stools, his magical but destructive power over his mother, and his regressive clinging control of his father became reduced. The erotization of all these became less.

This is a success story told to illustrate the items I have isolated out for consideration in the family developmental cycle from a psychoanalytic frame of reference. It suffers from over-condensation. Each of the familial developmental phases to which I have repeatedly referred could be talked about in far greater illustrative detail.

What is crucial to keep in mind, I believe, is the fact that in each developmental phase, all family members have the opportunity to mature and expand their ego functions. The potential is always present in a family for a dyadic and/or group regression which then becomes systematized and, in greater or lesser degree, affects the developmental progress of the whole family. Subsequent developmental transitions may fail because of the resistance to change which characterizes these subsystems.

SUMMARY:

I have used a developmental frame of reference as a way of viewing the emergence and/or perpetuation of psychopathology in a family. This frame of reference includes several accompanying concepts if it is to be understood.

These are:

A. Resistance to change as a fundamental dynamic factor in field (family) pathology.

B. Interpersonal subsystems within a family acting as perpetuators of pathology and as resistants to change.

C. Phase-appropriate adaptations by the family. Five in the early years of childhood are:

1. Basic nurturing.
2. Encouragement of emerging autonomy.
3. Organizing instrumental action.
4. Clarifying reality.
5. Facilitating dyadic relationships.

D. Pathologic compensatory mechanisms operating within a family operate so as to insure the success of each of the above phases for the children but at the penalty of creating interpersonal subsystems which resist change and normal developmental progressions. The consequence is a high potential for pathology or a perpetuation of existing pathology.

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